April 5, 2012

Submitted via email to <u>ActuarialValue@cms.hhs.gov</u>

Center for Consumer Information and Insurance Oversight Department of Health and Human Services P.O. Box 8010 Baltimore, Maryland 21244-1850

Re: Patient Protection and Affordable Care Act: Actuarial Value and Cost-Sharing Reductions Bulletin

To Whom It May Concern:

Thank you for inviting comments on the Actuarial Value and Cost-Sharing Reductions Bulletin. The University of Michigan Center for Value-Based Insurance Design (V-BID) is pleased to offer these comments regarding the calculation of actuarial value for plans to be offered in the state health insurance exchanges.

The University of Michigan V-BID Center leads in research, development, and advocacy for innovative health benefit plans. Established in 2005, the Center works as a liaison between the research community and implementers – employers, plan designers, and policy makers to help synthesize and communicate research findings, and encourage the benefits of V-BID.

Overview of Value-Based Insurance Design:

Value-Based Insurance Design is one of the most innovative and widely implemented approaches to enhance clinical outcomes and control the cost of health care. A broad and diverse coalition of health care and business leaders across the country, as well as political leaders from across party aisles, support expanded utilization of V-BID programs to simultaneously address quality improvement and cost containment, both for preventive care and the management of chronic medical conditions.

The goal of V-BID is to structure health plan design elements to optimize patient health through increased utilization of evidence-based health care services. In particular, V-BID lowers financial barriers to high-value services and provides disincentives for low-value care. Restructuring health insurance plans to provide patient incentives for evidence-based care can help refocus the health care system

on quality outcomes rather than volume, especially if the provider payment system is restructured along similar lines.

V-BID principles and actuarial value:

The estimation of actuarial value is important to the use of V-BID principles by health plans of every kind, inside or outside the health insurance exchanges. Therefore, the Center is deeply appreciative of the Department of Health and Human Services's (HHS) consideration of V-BID in the context of tradeoffs that can arise from the use of an AV calculator. As the bulletin noted:

We also recognize the need to accommodate innovative plan design features that are meaningful to consumers, such as Value-Based Insurance Designs that vary the copayment or coinsurance for items and services based on expected value.1

Thank you for keeping in mind the impact that these regulations, once formalized, will have on the ability of plans to offer innovative new benefit designs, which may include V-BID principles. We ask that you continue to consider the impact of regulations on the use of value-based designs as you formalize the ideas outlined in the bulletin.

Policies that support the provision of evidence-based care through value-based designs have broad support. A form of V-BID will be offered in every health insurance exchange plan, thanks to Sec. 2713 of the Patient Protection and Affordable Care Act, which ensures that certain recommended, evidence-based preventive care services must be provided without patient cost-sharing.²

In addition, in its October, 2011 report to the Department of the Health and Human Services, the Institute of Medicine highlighted the need to build increased value into health plans offered in the exchanges, and specifically highlighted the role of V-BID in effecting that change. The report strongly endorsed the premise, central to V-BID, that clinical nuance should be a significant determinant of the benefits offered in the Health Exchanges, saying, "The committee believes that the EHB package should become more fully evidence-based, specific, and value-based over time."³ The report also noted, "Benefit design and its subsequent administration can be instrumental in addressing the cost and quality of services and care delivered. Insurers and employers are experimenting with an array of medical management and cost-sharing

¹ Actuarial Value and Cost-Sharing Reductions Bulletin, page 7. Accessed at: http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf

² See 26 CFR 41726 (July 19, 2010)

³ Institute of Medicine. Essential Health Benefits: Balancing Coverage and Costs. National Academies of Sciences, 2011: 23.

designs (e.g., value-based insurance design)."4

Support for the flexible actuarial value calculator:

The Center supports HHS's approach to defining actuarial values for plans such that consumers will be able to easily compare options within metal tiers. When consumers can see the differences in cost-sharing among plans, they may better identify and understand the added benefit of plans with value-based components. We also agree with HHS's approach of allowing plans to independently develop cost-sharing structures with actuarial equivalence to one of the metal tiers. This policy creates a flexible environment capable of promoting the use of value-based innovations.

Additionally, the Center supports the exceptions process outlined by HHS to facilitate actuarial estimates of innovative plan features. We recognize that it is inherently challenging to measure the impact of plan features that change patient behavior on actuarial value or plan cost. By their very nature, V-BID plans are not one-size-fits-all propositions; they are diverse in terms of cost-sharing arrangements and population targets. The field of value-based design is continuously evolving and producing new evidence; new data from evaluations of existing plans, including plans that will be offered in the state health insurance exchanges, will improve the accuracy of actuarial estimates for value-based designs (presumably, using an exceptions process rather than the standard calculator). Moreover, because most of the services subsidized by V-BID programs are either primary prevention (as mandated by Section 2713 of the ACA) or secondary prevention (management of chronic diseases, such as diabetes and depression), there may be a short-term increase in costs as a result of the enhanced use of these services. The expected associated cost offsets, through lower rates of future complications (e.g. heart attacks, cancer diagnoses) may not occur for several years.

Given these inherent challenges, both options offered by HHS for calculating an alternative actuarial value seem like reasonable processes to account for V-BID. In fact, we believe that most narrowly defined V-BID programs will operate within the bounds of the suggested *de minimis* variation allowance, so that value-based designs will generally not cause plans to disruptively shift from one metal tier to another. Taken together, these policies will allow plans to use sound actuarial principles to build innovative value-based insurance designs, resulting in more state exchange marketplaces offering clinically nuanced care.

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⁴ Ibid, 59.

Conclusion:

On behalf of the V-BID Center, thank you again for the opportunity to comment. Please contact me if you would like to discuss any of the issues we have raised in further detail.

Sincerely,

A. Mark Fendrick, MD

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Professor of Internal Medicine and Health Management & Policy Director, Center for Value-Based Insurance Design

University of Michigan